STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185170	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradford Square Nursing and Rehabilitation Center	1040 US 127 South Frankfort, KY 40601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51764 Based on observation, interview, record review, review of a police report, and facility policy review, the facility failed to follow its policy for the receipt of a Schedule 4 controlled medication (clonazepam) for 1 of 2 sampled residents, Resident (R) 32. On 01/02/2025, Licensed Practical Nurse (LPN) 2 signed the pharmacy's Delivery Receipt for delivery of R32's 15 tablets of clonazepam (a benzodiazepine, used to treat anxiety). However, review of the facility's Narcotic Sheet revealed R32 did not have an entry for the delivery of the clonazepam on 01/02/2025, and review of R32's Medication Administration Record [MAR] revealed R32 missed five doses of clonazepam because the facility did not have that medication. The findings include: Review of the facility's undated policy titled, 2.0 Receipt of Routine Deliveries, revealed the facility nurse or other facility representative, when routine medication deliveries arrived from the pharmacy, signed the delivery manifest and/or electronic signature pad, noted time of arrival, and took responsibility of the medications. Per the policy, if medications were not correct, for instance missing from the delivered pharmacy tote, the pharmacy must be notified within 24 hours, so the items could be resent. The policy also stated controlled substances were immediately logged into the facility's controlled drug inventory system in compliance with state or local regulations. Review of the facility's policy titled, Medication Storage, dated 08/04/2024, revealed controlled substances (listed as Schedule 2 through 5 of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse were separately locked in permanently affixed compartments, except when using a single unit package drug distribution system in which the quantity stored was minimal and a missing dose could be readily detected. Review of R32's Physician's Orders, dated 12/26/2024, revealed R32 was ordered clonazepam 0.25 milligrams (mg) orally and daily at bedtime. Review of R32's January 2025 MAR revealed R32 had an order for clonazepam 0.25 mg to be given orally at bedtime. However, the MAR revealed R32 did not receive doses for five nights because of missing medication on 01/03/2025, 01/05/2025, 01/06/2025, 01/07/2025, and 01/08/2025. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided Delivery Receipt, dated 01/02/2025, revealed clonazepam 0.25 mg, 15 tablets, was signed into the facility at 5:07 PM on 01/02/2025, and LPN2 signed the receipt for the delivery. Review of the facility's Narcotic Sheet revealed R32 did not have an entry for the delivery of the clonazepam 0.25 mg on 01/02/2025. Review of the Police Report, filed on 01/08/2025, revealed LPN2 made a statement that clonazepam 0.25 mg was signed into the medication cart on 01/02/2025. However, per the report, there were no entries on the narcotic record that the medication was signed into the cart. The police report stated the resident (R32) complained about not receiving the medication. Observation on 03/19/2025 at 9:07 AM revealed the pharmacy courier delivered medications to the facility in red sealed bags. The courier placed the medication bags at the nurses' station, LPN1 opened the bags, signed the delivery receipt, and kept a copy of the delivery receipt for the facility. Observation on 03/19/2025 at 10:00 AM revealed the Unit Manager (UM) unlocked the medication room, and several medications were noted in the room in plastic containers. When asked if there were any narcotics in the room, the UM stated no. She stated the room was used as a holding area for medications. During an interview with R32 on 03/19/2025 at 1:15 PM, R32 stated she was aware of the missing medication incident. She stated the UM told her the medication was lost. She stated the facility reordered the medication, and she had no further concerns about the incident. During an interview with LPN2 on 03/19/2025 at 11:45 AM, LPN2 stated, on 01/02/2025, she signed for a medication delivery from the pharmacy and placed those medications in the medication room. She stated she did not view the medications. She stated she did not believe the clonazepam was delivered to the facility. During an interview with LPN6 on 03/20/2025 at 10:37 AM, she stated she came to work for the evening shift, on 01/02/2025, and counted the medication cart with LPN2. She stated the medication count was correct. LPN6 stated that due to the facility being overstaffed she went home, but before leaving, she counted the cart with LPN8. LPN6 stated she was called in a week later for drug testing for the missing clonazepam. The State Survey Agency (SSA) Surveyor attempted to interview LPN8 by telephone. Phone calls were made on 03/20/2025 at 10:18 AM, 03/20/2025 at 2:15 PM, and 03/21/2025 at 9:30 AM. There were no answers, and the voice mail was full. During an interview with the Pharmacist on 03/21/2025 at 2:38 PM, he stated the medication (clonazepam) was delivered on 01/02/2025 at 5:07 PM. The Pharmacist stated there were no discrepancies in the count at the pharmacy. The Pharmacist stated the resident was not billed for the missing medication. He stated the medication was reordered on 01/08/2025 and required prior authorization. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 03/20/2025 at 2:00 PM, he stated he had been working at the facility since 12/26/2024. He stated he reported to the Administrator. He stated he had been trained by the Regional Director. He stated narcotics were to be signed directly into the cart and verified with two nurses. He stated he could not verify the medications were delivered to the facility. He stated he was in training at this time. During an interview with the Administrator on 03/19/2025 at 11:35 AM, he stated he was notified the medication was missing on 01/08/2025. He stated he started a facility investigation that included, calling the police, filing a police report, taking witness statements, and initiating drug screens for three employees, LPN2, LPN6, and LPN8. He stated all three employees were given a drug test and placed on leave until the drug test results came back. He stated none of the three tested employees came back positive for any traces of clonazepam. He stated LPN8 and LPN6 were no longer employed at the facility. He stated he could not verify that the clonazepam was delivered to the facility, and as a result, came to the conclusion that the medication was never in the building.